MHA MASSACHUSETTS HOSPITAL ASSOCIATION

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Registration of Provider Organizations Draft Data Submission Manual

May 15, 2015

The Massachusetts Hospital Association (MHA) on behalf of its member hospitals and health systems, appreciates the opportunity to provide comments to the Health Policy Commission (HPC) on its proposed Data Submission Manual (DSM). We recognize and appreciate that the HPC has convened several stakeholder meetings and has continued to modify the requirements in response to comments since the initial DSM was first published a year ago. We also understand that some of the information requested is necessary to inform the HPC and other state agencies regarding analysis of the overall health care environment. However, we continue to have concerns regarding the amount, nature, and complexity of the information being collected as well as the fact that a significant amount of the required elements duplicates what can be obtained from other state agencies.

As stated in Governor Baker's press release regarding his executive order initiating regulatory reform, "Only those regulations which are mandated by law or essential to the health, safety, environment, or welfare of the Commonwealth's residents shall be retained or modified." The order asks state agencies to eliminate or modify regulations where the costs exceed the benefits and result in duplicative, intrusive, or restrictive requirements, are anti-competitive, or could adversely affect the citizens and customers of the commonwealth. We ask that the HPC be mindful of the intent of this executive order as it considers the best way to move forward on the registered provider organization (RPO) regulatory process.

General comments

Our members continue to struggle with the length and complexity of the 49 pages long DSM and the fact that the HPC requires information that goes far beyond what is statutorily required. For example:

- The definitions and the elements are often confusing and must be read multiple times in order to discern what is actually being requested. The DSM sometimes uses the defined (capitalized) terms and other times uses the same words without capitalization. It is difficult to determine HPC's intent based on the inconsistent usage of defined terms.

- **RPO 51-53** asks for the name of the contracting entity that establishes contracts on behalf of the corporate affiliate although this is followed in the next section by an entire file with multiple questions on contracting affiliates and entities. In fact there are several sections where it appears that the RPO will have to repeat information that has already been provided.
- **RPO 56-57** appears to duplicate information that is available from the corporate organizational chart.
- **RPO 66** requires the RPO to provide the name of each contracting entity that establishes contracts on behalf of a contracting affiliate. The RPO is not always in a position to know all of the entities that establish contracts on behalf of their contracting affiliates and this should be outside the scope of the RPO's filing.
- Regarding the **Physician Roster File**, the DSM states that a separate physician roster must be submitted for each of the RPO's contracting entities. In some cases, the RPO will have multiple contracting entities that establish contracts on behalf of the same physicians (e.g., a PHO and a physician organization) resulting in the same that the same information being reported multiple times.
- **The Physician Roster File** requires the EIN in several locations. In the case of a solo practitioner, it is possible that this could be the social security number. Providing this information in a file that can be publicly disclosed is not acceptable.
- In some instances, the elements or definitions are duplicative or appear to actually conflict with one another. For example, **RPO 104** asks for the primary medical office where the physician provides care. **RPO 122** asks for the name of the medical group with which the physician is affiliated. What is the difference? Some of the information in the corporate and contracting affiliations file (organization type, legal name) is repeated in the facility files (facility name, license type). **RPO 71** duplicates questions already answered in the contracting affiliations file. Again, it is unclear what the HPC is trying to ascertain with this particular question.
- **RPO 126 and RPO 130** require the RPO to list each organizational NPI associated with Local Practice Groups. As this information is requested for each physician, the same information will need to be provided multiple times (i.e., for each physician in each Local Practice Group). This reporting also appears to duplicate information already provided in the Physician Roster File.

The DSM needs to be further streamlined so that the information is asked clearly, concisely, and most importantly is not duplicated in numerous sections.

<u>Duplicate Reporting Requirements</u>

Chapter 224 states that "The commission shall coordinate with state agencies including, but not limited to, the center, the division of insurance, the executive office of health and human services, the office of Medicaid and the department of public health to minimize duplicative

reporting requirements. The commission may enter interagency service agreements to perform these functions including but not limited to the sharing of data collected. The commission, in consultation with the center, shall promulgate such regulations as may be necessary to ensure the uniform reporting of data collected under this section."

Although the HPC has repeatedly stressed that it strives to minimize the administrative burden placed on providers and will work to reduce duplication and to obtain information from other state agencies whenever possible, there are still significant challenges posed in the DSM. For example, instead of obtaining facility licensure information directly from DPH, the DSM requires each provider organization to supply this information. Instead of getting physician information from BORIM or from Mass Health provider enrollment, the provider organization is expected to duplicate what has already been provided to the state. Obtaining this information from the relevant state agency would reduce the significant administrative and financial burden that the HPC is placing on providers with these duplicative requirements. It would also fulfill the goal in Chapter 224 that stresses sharing of data collected by state agencies to ensure the uniform reporting of the data. Rather than transferring the burden to providers, the HPC should be working with the other state agencies to develop a single process for collecting and sharing this information, eliminating redundancy, and creating one "source of truth" for information.

Additional Concerns

- **RPO 58-61 requires reporting on unassociated corporations**. MHA members question the necessity of providing this information and would like to understand its value to the HPC and how it will be used, as it is an additional burden to collect this significant and detailed amount of information on entities that have no direct affiliation to the registering provider organization. Collecting information solely for the sake of collecting information is a poor use of everyone's time.

- **RPO73-77 requires detailed information about global payments** and how they are dispersed across contractual affiliates. This is not statutorily required. Like some of the other information that is requested, this is burdensome to provide for each contracting entity and due to the possibility for public disclosure, can have serious unintended consequences, particularly where businesses compete and services overlap. MHA urges the HPC to eliminate this requirement entirely or to allow for a very high level general response (eg. RPO-73 only) that will not compromise each provider organization's proprietary information and create an anti-competitive environment. Additionally, the DOI collects information on alternative payment methodologies from all entities that are certified as risk bearing provider organizations.
- **RPO-70** asks for the **date range when the contracting entity first began establishing at least one contract in that group**. While MHA appreciates that the HPC simplified this question, we are still unclear why this information is even necessary since virtually every provider organization will have established contracts with the major commercial payers. The relevant fact should be whether the entity *currently* has contracts within each of the specified categories, not when those contracts were initiated.

Clinical affiliations file

MHA continues to have concerns regarding the broad based requirements for providing information about each clinical affiliation as defined in the DSM. Similar concerns have been submitted to the HPC regarding the requirements for filing notices of material change. As with the notices of material change, there should be a materiality threshold that determines what should be reported. Provider organizations may literally have hundreds of what the HPC would consider a reportable clinical affiliation. Routine affiliations such as a shared coverage arrangement between two pediatric offices or a physician leasing office space should not have to be reported as clinical affiliations.

Additionally, any clinical affiliation that has already been reported to the HPC though a notice of material change should be exempt; instead the RPO should be able to indicate "already on file with the HPC."

Conflict with other state and federal requirements

In addition to the RPO requirements, many of these same provider organizations are subject to the DOI's risk bearing provider certification process, and/or will be working on the HPC's Patient Centered Medical Home certification standards, HPC cost trend hearings, HPC ACO certification process, as well as the CMS Medicare Shared Savings Program and Next Generation ACO program. All providers will have to comply with the move to ICD-10 in October. For many hospitals, the HPC timeframe also coincides with the close of the fiscal year. Given the many conflicting priorities, we would encourage the HPC to allow additional time beyond the September 30th deadline to complete the RPO process, ideally until the end of 2015.

We appreciate the opportunity to provide the HPC with comments that reflect the concerns of our members. In closing, we would again remind the HPC of Governor Baker's executive order that states "the citizens and customers of the Commonwealth will be better served by reducing the number, length, and complexity of regulations, leaving only those that are essential to the public good." The order also states that each Agency shall insure that every regulation is clear, concise, and written in plain and readily understandable language. We sincerely hope that the HPC will consider the financial and administrative burdens that the DSM requirements are placing upon the entire provider community, often without clear benefit, and will comply with the spirit of Governor Baker's executive order. We strongly encourage the HPC to streamline and simplify the proposed DSM through eliminating duplicative requirements, confusing language, and the reporting of superfluous information that does not serve to improve the health, safety, or welfare of the Commonwealth. Thank you.